Partnership HealthPlan of California, H5782
Dual-Eligible (Medicaid Subset - $0 Cost Share) Special Needs Plan

Model of Care Score: 86.88%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Partnership HealthPlan of California (PHC) serves 167,000 Medi-Cal members across Solano, Napa, Yolo and Sonoma counties in California with 31% of its population falling in the 65-74 years age group. The target population of PHC is broken into two ethnicity groups with 22% of the population identifying as Hispanic or Latino and the remaining 78% identifying as non-Hispanic or Latino. From the population, 20% have been diagnosed with chronic obstructive pulmonary disease and 27% have been diagnosed with diabetes, while 84.5% of the diabetics also have cardiovascular issues.

Provider Network

PHC's provider network includes facilities pertinent to the care of the targeted special needs population, which includes inpatient acute hospitals, acute rehabilitation, inpatient skilled nursing, outpatient services, dialysis facilities, medical specialists, behavioral and mental health, nursing professionals and allied health professionals. Each member of the interdisciplinary care team (ICT) has access to reports on delivered services and can access the electronic data collection tool which contains service activity data through utilization claims and encounter data submitted by network providers.

Care Management and Coordination

The member's health risk assessment (HRA) provides an initial assessment of member health status, including condition specific issues, assessment of their activities of daily living, functional status, mental health status, psychosocial needs, cognitive functions, life-planning activities, cultural and linguistic needs or preferences, visual and hearing needs or preferences/limitations and caregiver resources and involvement. The plan conducts the initial assessment within 90 days of member enrollment and then a reassessment annually thereafter. The health care coordinator (HCC) enters the HRA into the data system, which scores the HRA and can categorize members as high risk. The HCC also sends a copy of the HRA to the member's primary care physician (PCP) in writing and other members of the ICT via secure facsimile or email.

The PCPs develop an individualized care plan (ICP) for each member and include that care plan in the member's medical record. The PCP involves the member in the development of the ICP at the time of the assessment visit and updates the plan as needed in subsequent visits. Each care plan includes results of the HRA, goals and objectives, specific services and benefits, outcome measures, preferences for care and any add-on benefits available. All follow-up contacts with the

member, PCP and/or specialty care results in a review and revision of the ICP. PHC documents the ICP in a secure shared patient file accessible to the interdisciplinary care team (ICT) and saves their contact information in an electronic case management record. The plan will review and revise the ICP at least annually or as a change in health status is identified and discuss changes made in the plan of care with the member and any appropriate participants in the ICT.

The ICT is a team of health care and other professionals who analyze and incorporate the results of the HRA into the member's ICP, update the ICP annually, manage the needs of the enrollee and communicate to coordinate the ICP. The initial meeting of the ICT usually includes the chief medical officer, an associate or regional medical director, health services director, manager of care coordination, complex care manager and health care guide. PHC verbally advises the member of the need for the ICT and invites him/her to participate in the meeting via phone and informs the member that their care manager may contact them after the meeting to discuss the plan of care. PHC has a variety of network professionals available to participate in the ICT, including (but not limited to) physicians, nurse practitioners, nurses, behavioral health providers, social workers, pharmacists, nutritionists and health educators.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses member needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.partnershiphp.org